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# Clinical Interventions that Reduce Recidivism among Female Offenders: A Systematic Review

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Clinical Interventions that Reduce Recidivism among Female Offenders:  
A Systematic Review

by

Brittani J. Senser, BSW

MSW Clinical Research Paper

Presented to the Faculty of the  
School of Social Work

St. Catherine University and the University of St. Thomas St. Paul, Minnesota  
in Partial fulfillment of the Requirements for the Degree of Master of Social Work

Committee Members

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

## Abstract

In this systematic review, literature concerning clinical interventions that reduce recidivism among female offenders was reviewed and analyzed. Using the databases PsycINFO and Criminal Justice Abstracts Full Text, 10 studies regarding clinical interventions met the criteria for this systematic review. All studies were analyzed by specific clinical interventions that were conducted while females were in prison and or after release. The findings focused on what interventions work specifically for women to reduce substance abuse issues, post-traumatic stress disorder, and mental health diagnoses. Implications for future research include identifying interventions that are directly linked to the reduction of recidivism.

## Acknowledgments

In 2013, I decided to go back to college after being out of high school for over 10 years. When I decided to go back, I made a commitment to myself that I would finish my undergraduate degree in 3 years and my masters in 1 year. I was determined and committed. I took multiple summer class and J-term classes so I could finish in this “relatively impossible” timeline. Because of that, my time at home was extremely limited. However, I knew my goal was to better my own life and the life of my daughter.

I dedicate this clinical research paper to my daughter, Aria Joy Burch Senser; you give me purpose. I am forever grateful for the personal time with me that you sacrificed so I could complete this journey. You are my inspiration and the reason I push myself to be GREAT. Thank you for being my biggest advocate and greatest motivation. Your love and approval have made every tear, every paper, every assignment and every practicum hour worth it. And yes, I will take you to Japan!

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## Table of Contents

Introduction.....	1
Literature Review.....	4
Conceptual Framework.....	12
Methods.....	15
Findings.....	18
Discussion.....	33
Conclusion .....	37
References.....	38

## Lists of Tables

Table 1. Studies Reviewed: Clinical Interventions that Reduce Recidivism.....	19
Table 2.1. Summary of Research Articles .....	20
Table 2.2. Summary of Research Articles, cont .....	21
Table 2.3. Summary of Research Articles, cont .....	22
Table 2.4. Summary of Research Articles, cont .....	23
Table 2.5. Summary of Research Articles, cont .....	24

## List of Figures

Figure 1. Diagram of study selection process .....	17
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**Introduction**

Within the context of the criminal justice system, recidivism is one of the most significant challenges for criminal justice professionals. Recidivism refers to a person's return to criminal activity after release from a previous conviction. According to the National Institute of Justice (NIJ, 2016), "Recidivism is measured by criminal acts that resulted in rearrests, reconviction, or return to prison with or without a new sentence during a three-year period following the prisoner's release" (para. X). In addition to the difficulty measuring the causes of recidivism, recidivism rates are also difficult to measure and compare, as some research groups base rearrests or reconviction on a three-year basis and others on a five-year basis.

The United States has the largest prison population in the world. One in every 100 American adults is currently incarcerated (Blumstein & Beck, 1999). There are a total of 2.2 million inmates in U.S. federal, state, and county jails or prisons (Nellis, 2016). According to Zoukis (2016), there is a 76.6% recidivism rate out of state prisons and a 44.7% rate out of federal prisons. Within the last 40 years, American incarceration rates have increased drastically. The U.S. "War on Drugs" in the 1980s and 1990s made the production, consumption, and distribution of drugs one of the most pressing issues in the criminal justice system. These Drug Policy initiatives are estimated to cost the United States around \$40 billion each year (Schrager, 2013).

It was not until 1873 that the first female penitentiary was opened, while still being attached to a male facility. At that time, institutions were designed similarly to and had the same philosophies as male correction units. Even over 100 years later, in 1980, the number of women

in state and federal prison was under 20,000 (Institute for Research, Education & Training in Addictions [IRETA], 2014). However due to the minimum mandatory sentences that were part of the War on Drugs, women's incarceration rates grew rapidly. Since 1995, female offenders make up one of the fastest growing criminal justice populations with an increase rate of 5% as compared to men at a 3% increase since the "War on Drugs" (Bureau of Justice Statistics, 2004).

Incarcerated women have different needs than incarcerated men, particularly with regard to responsiveness toward their respective—and often different—psychological and emotional needs. These needs may or may not have been addressed outside of prison prior to incarceration and could potentially have played a role in criminal behavior. Substance abuse disorder, post-traumatic stress disorder, and other mental health issues are some of the main psychological issues new female inmates face. Some interventions have been incorporated into prisons to reduce the chances of inmates returning to criminal behavior. However, the current methods of rehabilitation are sporadic and inconsistent. In fact, Brewster et al. (2002) argued that, in U.S. prisons, "rehabilitation efforts fail to ensure changes that will remain after release" (p. 329).

In America's state and federal prisons, 650,000 inmates are released from prison each year. Many inmates are released with no money, limited education, minimal options for employment, and limited housing available to felons, making reintegration into society difficult. Another significant barrier for newly released inmates is social stigma. Dickson (2014) argued that stressful and unsafe prison conditions and lack of support post-release can "set up" inmates for recidivism. When newly released inmates don't have resources, can't work, and can't find a place to live, they are much more likely to fall back into criminal behavior which increases the chances of recidivism.

Combining interventions offered in and out of prison is crucial to reducing recidivism. The needs of rehabilitation are different for males and females, and research shows that clinical interventions in prisons are more effective when they're gender-specific. Therefore, this systematic review will examine certain interventions currently being used specifically for female inmates while in prison and after prison that reduce recidivism, as well as explore their strengths and limitations and how practice implications can be improved. This systematic review will attempt to answer the following question: What clinical interventions can be used that will reduce recidivism among female offenders?

## **Literature Review**

### **History of Recidivism Interventions**

In the 1800s, the ideal of the penitentiary was to reform offenders in order to make them “less criminal” (Cullen & Gendreau, 2000). According to Cullen and Gendrea, “The very word ‘penitentiary’ suggests that the prison was not to be a place where offenders were merely warehoused or suffered their just deserts, but rather that the experience of incarceration was to transform their very spirit and habits of living” (p.114). Some scholars believe that the idea of prison was to take them out of a chaotic and criminalist environment and place them in secure institutions to transform them into productive workers (Cullen & Gendreau, 2000). Up until the early 1900s, nearly all penitentiary reforms were Christian efforts, and the idea of “doing good” by reforming prisoners was based in Christian ideals. There was a strong connection between religion and rehabilitation.

In 1870, practitioners met in Cincinnati for the National Congress on Penitentiary and Reformatory discipline. Attendees argued that the aim for prison was the reformation of criminals. According to Wines (1871), “The prisoner’s destiny should be placed, measurably, in his own hands, he must be put into circumstances where he will be able, through his own exertions, to continually better his own condition. A regulated self-interest must be brought into play, and made constantly operative” (p. 541). It was believed that people offended because they lacked morals and because of an array of social and psychological factors. Prison-based treatment was based around individual needs and circumstance of each individual.

### **Development of Intervention Approach**

In 1954, the American Prison Association changed its name to the American Correctional Association and prisons were relabeled “correctional institutions.” Over the following 20 years,

“an array of ‘treatment’ programs were introduced inside prisons, such as individual and group counseling, therapeutic milieus, behavioral modification, vocational training, work release and furloughs, and college education” (Cullen & Gendreau, 2000, p.118). However, implementing these programs was difficult because of the lack of trained staff and resources. According to Cullen and Gendreau, 1974 was the year of “the decline of the rehabilitative ideal” (p. 119). They cite Martinson (as cited in Cullen and Gendreau, 1974) as seminal in spreading a pessimistic attitude toward rehabilitating offenders, calling it a “failed enterprise” (p.119). Martinson’s research would ultimately convince criminologists and other people associated with corrections that “nothing works.” This shook the ideals of rehabilitation efforts.

### **Incarceration of Women**

According to Mallicoat (2011), “Prior to the development of the all-female institution, women were housed in a separate unit within the male prison” (p. 461). This arrangement ultimately resulted in an excessive use of solitary confinement along with significant instances of physical and sexual abuse by male inmates and guards (Mallicoat). It wasn’t until 1873 that the first stand-alone facility for women was opened in the United States, with the number of occupants at 16. The initial intent was to rehabilitate women; there were no specific periods of incarceration for the women (Mallicoat). Institutions were designed and had the same philosophies as male correction units. In the 1980’s, particularly because of the minimum mandatory sentences associated with the “War on Drugs,” women’s incarceration rates increased significantly (Mallicoat). The “War on Drugs” disproportionately affected and continues to affect women; 29% of women were incarcerated for drug related offences as compared to 19% of men (Flowers, 2010). The most recent correctional census indicated that more than 1.3 million women are under the control of the criminal justice system in the United States (Flowers, 2010).

## **Gender Responsive Interventions**

In many ways, female offenders are very different from male offenders. The pathways to criminal behavior are more influenced by life experience and perspective (Flowers, 2010). Research states that women's crimes are typically less severe than those of men. According to Mallicoat, women have been severely neglected by the prison system throughout history. It wasn't until the 1970s that "prison advocates worked toward providing women with the same opportunities for programming and treatment as men" (Mallicoat, 2011, p. 467). After many court cases, feminists and criminologists who fought for gender-based policies realized that programs designed for men do not meet the needs of women. A new gender responsive philosophy for programming was established, founded on six key principles: (a) gender, (b) environment, (c) relationships, (d) services and supervision, (e) socioeconomic status, and (f) community. According to Mallicoat, women respond to treatment differently depending on rehabilitation (p. 467). By not offering gender specific programming, practitioners are not addressing the unique needs of either gender. According to Drapalski et al. (2009), women are more likely to understand the need for treatment and have a more positive attitude towards mental health programs and are more prone to seek treatment. Gender-specific treatments that address women's unique needs during incarceration and after can dramatically impact a woman's chances of reoffending.

## **Risk Need Profile**

Justice Reinvestment, a program committed to undoing the effects of mass incarceration in the United States, hopes to increase correctional programming to reduce recidivism through evidence based practice (Taxman et al., 2014). They believe that expanding access to programming and participation in programs can reduce recidivism. By offering Risk-Need-

Responsivity (RNR), they anticipate re-incarceration rates can be reduced by 3-6% (Taxman et al., 2014). The Risk-Need-Responsivity framework assigns correctional interventions based on several criteria, including the following:

- Criminal history of the individual (static risk that determines the level of control and structure to achieve behavioral change).
- Risk factors or criminogenic needs (employment history, mental health, substance abuse, education history).
- Matched to programming based on stabilizing, cultural, age and developmental factors that would improve progress.

According to Taxman et al. (2014), “Expanding evidence-based programming and treatments, both in terms of the nature of the programs offered and the percentage of offenders involved in programming, is an important key to achieving high expectations for justice reinvestment. In fact, it is the main strategy that will focus attention on recidivism reduction, providing a supportive environment for programming and offender change, and expanding the ability of the justice system to match offenders to more appropriate services” (p. 69).

### **Substance Abuse**

Amongst female offenders, drug and alcohol abuse rates are extremely high, surpassing the rates of their male counterparts (Nicholls et al., 2015). Around 80% of women in state prisons have issues with substance abuse (Center for Substance Abuse Treatment [CSAT], 1997). According to Nicholls (2015), “Research suggests that women are more prone to use substances as a coping mechanism to alleviate psychical, sexual and psychological victimization. This association between substances and victimization has been theorized to serve as a gendered etiological conduit in female offenders whereby drug use mediates the relationship between

trauma and aggression, which serve to perpetuate criminalization” (p.88). Bloom et al. (2004) further noted that “about half of women offenders in state prisons had been using alcohol, drugs or both at the time of their offense. On every measure of drug use, women offenders in state prisons reported high usage than their male counterparts—40% of women offenders and 32% of male offenders had been under the influence of drugs when the crime occurred” (p. 480).

There are types of interventions that are provided for women outside of incarceration for substance abuse that are known to work and to be effective. However, these programs are not necessarily available to women while they are incarcerated. These interventions include Dialectic Behavioral Therapy, which Linehan (1993) suggested is one of the most effective treatment forms for substance use disorders. Dialectic Behavioral Therapy is used as a behavioral treatment to address the synthesis of two opposites, which helps reduce problematic behavior, enhance symptom management, and create emotional regulation. Cognitive Behavioral therapy (CBT) is another common intervention for substance abuse disorders used frequently on non-incarcerated populations. CBT corrects or identifies problematic behavior and addresses what drives the behavior; the assumption is that the substance abuse itself isn’t the problem, but is rather caused by another non-addressed underlying need.

## **Mental Health**

The rates of mental illness diagnoses in prison are far higher than those outside of prison. Drapalski (2009) estimated that based on DSM criteria, mental illness rates could be as high as 70% of the prison population. The Bureau of Justice Statistics (2005) stated that mental health in incarcerated women is higher than it is in men. Common mental illnesses for prisoners include: substance abuse disorder, posttraumatic stress disorder, major depression, and psychotic disorders (Drapalski et al., 2009). Most state and federal prisons offer anger management classes



as well as addiction programs like Alcoholics Anonymous, but few mental health programs are designed specifically with women's needs in mind. Mental health treatment for incarcerated women tends to be pharmaceutical, focused more on controlling problematic behavior than on improving symptoms by addressing root causes (Taylor, 2015).

### **Social Support**

Pettus-Davis et al. (2015) discussed a relatively unexplored area of social support and reentry interventions, using qualitative and quantitative data to show that skill groups within prison are much appreciated. However, recommendations for engagement preparation with social support systems were a common concern. According to Pettus-Davis et al., "Studies have shown that in the period immediately after release from prison, as many as 92% of reentering prisoners rely on loved ones for instrumental forms of social support such as housing, clothing, food, child care, transportation, and financial and employment assistance" (p. 53). Incarceration can socially isolate prisoners from sources of support, so interventions to enhance support are crucial.

Pettus-Davis et al. (2015) integrated Hirshi's (1969) social bond theory, Catalano and Hawkins' (1996) social development model, and Cohen, Underwood, and Gottlieb's (2000) social support main effects model. The goal was to help prisoners acclimate to reentry and to help them navigate the transitional period, a time when prisoners typically need to rely heavily on social support (Pettus-Davis et al., 2015). The intervention helped build problem solving skills and communication skills while practicing self-reflection, and "more than 90% of reentering prisoners indicated that [the intervention] helped them to learn how to work through their problems and to developed new ways of getting help from others" (Pettus-Davis et al., 2015, p. 67).

## **Barriers**

According to Flowers (2010), “The majority of female offenders are economically marginalized and face substantial challenges when they return to the community after a period of incarceration” (p. 4). Women offenders face lack of education and employment barriers; they work fewer hours and make less per hour than male counterparts (Flowers, 2010). Unfortunately, according to Bloom et al. (2004), “Many correctional facilities offer little in terms of gender-specific vocational training” (p. 485). Flowers (2010) also stated that offenders are less educated than the general population, with only 51% having a high school diploma or a General Equivalency Diploma (GED). Additionally, only 52% of correctional facilities for women offenders offer postsecondary education and even when female offenders do have access to these courses or degrees, they are not eligible for Pell Grants (Bloom, 2004). Furthermore the Higher Education Act of 1998 denies eligibility to students who have been convicted of drug offenses (Bloom, 2004). Education and experience are the biggest factors in getting a job. Having a job can be a vital part of steering away from criminal behavior (Flowers, 2010),

Public housing is not always an option for formerly-incarcerated women. A lot of public housing services are not “felon friendly.” Public Housing Authorities, under the federally authorized “One Strike Initiative,” can obtain criminal conviction records from all applicants (Bloom et al., 2004). Section 8 providers can deny housing to individuals who have been convicted of a drug crime (Bloom et al., 2004).

## **Welfare**

Mallicoat (2008) noted that “while women may turn to public assistance to help support their reentry transition, many come to find that these resources are either unavailable or are

significantly limited” (p. 471). Federal public assistance has time limits and some states won’t provide public assistance to former incarcerated women at all. According to Mallicoat, of 51 states and territories,

- 15 deny benefits entirely
- 11 partially deny or grant based on terms,
- 12 enforce that benefits are dependent on drug treatment
- 13 opt out on a welfare ban

The Sentencing Project (2006) noted that as of 2006, 92,000 or more women were affected by the lifetime welfare ban. This means children with formerly-incarcerated parents also suffer. According to Mallicoat (2011), “the denial of benefits places more than 135,000 children of these mothers at risk for future contact with the criminal justice systems due to economic struggles” (p. 471).

## **Conceptual Framework**

The purpose of this study is to examine current literature on interventions for reducing recidivism among female offenders through an ecological approach and evidence-based practice lens. A conceptual framework uses past research to determine a theory and approach for a current research project.

## **Ecological Framework**

The ecological framework provides a conceptual framework for this systematic review because of the different lenses applied within the context of recidivism. The ecological framework consisted of four systems: (a) microsystem, (b) mezzosystem, (c) exosystem, and (d) macrosystem (Bronfenbrenner, 1994). This particular framework blends systems and developmental theories, stating that human development is influenced by multiple types of environmental systems. The microsystem is defined as the immediate surroundings of the individual such as family, school, or work (for incarcerated individuals, this would include fellow inmates; for those in the re-entry period, it would include family, friends and co-workers); the mezzosystem is defined as communities or neighborhoods (for incarcerated and formally incarcerated individuals this might include a support group or therapy group); the exosystem is defined as systems that indirectly influence an individual (for inmates, this might include, for instance, the “War on Drugs”); and finally, the macro system is defined as a system which guides and shapes organizations on a global or national level, such as the economy and state or global policies. The chronosystem is the ecological framework within the context of history over the span of a lifetime. For the purpose of this systematic review, the ecological framework will be analyzed and demonstrated through the micro, mezzo, and macro levels

The Ecological framework from a micro level addresses the individual's relationships with family, friends, home or work. For many incarcerated females, these relationships are strained. Because of the lack of visitation, relationships can be negatively affected, which ultimately effects the female offender after release. The Ecological framework from the mezzo level addresses the community that surrounds the individual, such as community programing, school, and work. The mezzo level for past offenders reintegrating into society can be impacted significantly by the social stigma that goes along with being a felon.

The Ecological framework from a macro level addresses the relationship between and individual and "the system", or how an individual is impacted by public policies, federal laws, state laws, culture, economic systems, and social conditions. It is the definition of the culture the individual lives in. Laws and bans greatly affect incarcerated women from having a chance to provide for themselves after reintegration. In addition to social stigma, laws and systems are in place that prevent them from successfully obtaining basic needs, like housing and employment.

### **Personal Motivation**

This topic is very important to me on a personal level. I have had numerous family members that have been to prison. Most of them have not reconvicted. I started to wonder why some are more prone to reoffend than others. I have noticed that their choice to reoffend must depend on resources and support during prison and after release. My step -mother spent 22 months in prison for vehicular manslaughter. She had the support of my family and limited financial issues when she came out of prison. She would say herself that she is far better off than most of the people she met while in prison. However, even without any financial burden, reintegration is still extremely difficult. The social stigma is so high, even as a college educated

white woman. Just the word “felon” will follow these inmates for the rest of their lives. I wanted to know what exactly was being done in prisons to ensure rehabilitation.

### **Professional Motivation**

Personally, I am astonished by the number of people in our prison system in the United States. Mass incarceration has affected so many men and women, families, and communities. In 2010, President Obama mandated that all federal prisons have reentry coordinators in the “Second Chance Act.” The primary role of a reentry coordinator is to help prisoners reintegrate back into society. This has become a high demand job for social workers in the criminal justice system. Their primary goal is to help current inmates to resolve issues through training, life skills development, home visits, and case management. There are many social workers who work on a micro level together with probation officers and parole officers. Social workers also work at a macro level, engaging in advocacy and creating systematic change. I see myself working in the future on policies and programs that could be implemented in state and federal prisons that reduce recidivism.

## **Methods**

By examining current literature on recidivism, I obtained a broad overview of recidivism in the context of the criminal justice system, the application of techniques and models of intervention, the population on which interventions are used, and the documented outcomes. Due to the paucity of literature currently available regarding interventions that focus on incarcerated women, there are very few clinical trials that link specific interventions to the reduction of recidivism. I conducted this systematic review in order to answer questions about interventions that can reduce recidivism in incarcerated women post-incarceration.

There are several questions regarding the reduction of recidivism that I aimed to explore in this study. The focus of this study is to examine and identify interventions and models addressing recidivism in the current literature. Additionally, areas of focus on interventions will be identified and analyzed in this systematic review to create a working recommendation of types of interventions proven to reduce recidivism.

### **Selection Criteria**

The objective of this study was to review all available published studies that (a) explored clinical interventions for incarcerated women theoretically or empirically, (b) identified recidivism intervention theoretical foundations or frameworks, and (c) discussed the specific components incorporated in reduction of recidivism programs pre-and post-release.

Since the preliminary search for literature identified thousands of articles varying in relevance to this research project, only articles that contained clinical intervention terminology and/or the phrase “reduction of recidivism among female offenders” in the title were considered for initial inclusion. All unpublished studies and dissertations were also excluded. All studies that met search criteria were reviewed.

## **Search Strategy**

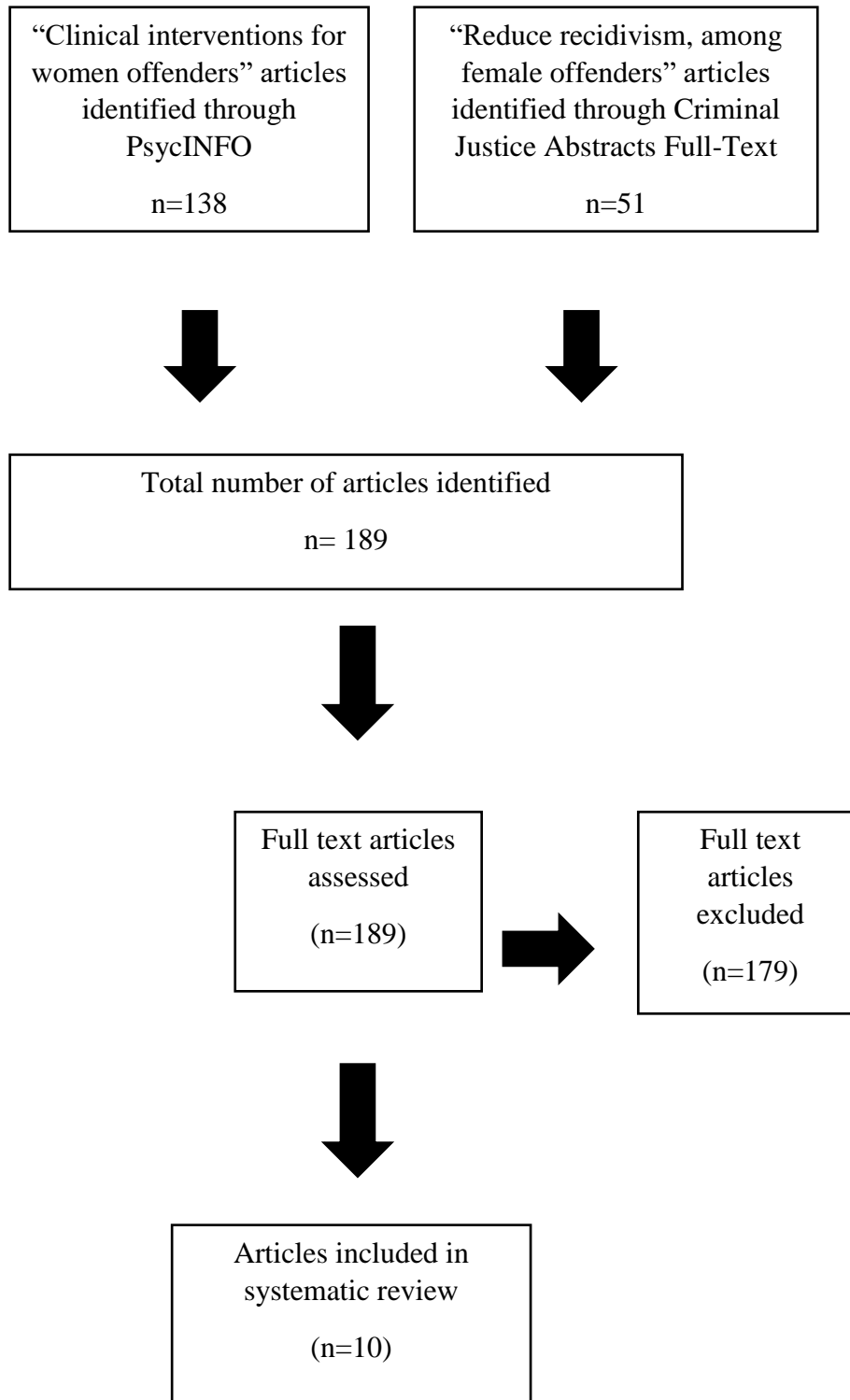
The literature search was conducted between September 2016 and January 2017 using the data base Criminal Justice Abstracts Full-Texts and the search phrase “reduce recidivism among female offenders.” The preliminary search returned 51 studies. Studies were eliminated based on age, specificity and severity of crime, sexual violence, and DUI offences. The studies used for this systematic review were analyzed as a community.

The other database used for this systematic review was PsycINFO (PSYCnet). A search term on the phrase “clinical interventions for women offenders” produced 138 results. The clinical trials that I chose for this systematic review were ones where interventions were actually performed on the female prison population. Ten studies were used for this systematic review from both search terms. The 10 clinical interventions were reviewed by my research chair.

## **Data Abstraction and Analysis**

I analyzed data from the ten studies carefully, five separate times, for this systematic review, and obtained any other important data during the reviews of the clinical trials. For the first clinical review, I extracted data to determine what worked for women to reduce recidivism. In the second critical review I determined specific interventions that helped women with identifying and building skills to reduce criminal behavior/recidivism. Once I reviewed the data I organized it into summary tables for synthesis and analysis of the 10 clinical trials. Figure 1 shows a diagram of my research process.





**Figure 1.** Diagram of study selection process.

## **Findings**

For this systematic review, ten clinical interventions met the selection criteria. The Findings chapter will summarize the studies by breaking down the interventions into two categories: cognitive/behavioral (five studies) and support during and after incarceration (five studies). Table 1 shows the 10 studies used for this systematic review, while Tables 2.1-2.5 show the study components in more detail. When analyzing interventions that reduce recidivism, two focuses seemed to be the most prevalent: Interventions while in prison, whether cognitive or behavioral, and support post-incarceration.

Table 1

*Studies Reviewed: Clinical Interventions that Reduce Recidivism*

<b>Number</b>	<b>Author</b>	<b>Year</b>	<b>Title</b>
1	Wolff, Frueh, Shi and Shulman	2012	Effectiveness of cognitive-behavioral trauma treatment for incarcerated women with mental illnesses and substance abuse disorder
2	Grills, Villanueva, Anderson, Corbie-Massay, Smith, Johnson, and Owens	2015	Effectiveness of choice theory Connections: A cross-sectional and comparative analysis
3	Heideman, Cedarbaum, and Martinez	2016	Beyond Recidivism: How formally incarcerated women define success.
4	Lovins, Lovenkamp, Latessa, and Smith	2007	Application of risk principle in female offenders
5	Ford, Chang, Levine, and Zhang	2014	Randomized clinical trial comparing affect regulation and supportive group therapies for victimization-related PTSD with incarcerated women
6	Sacks, McKendrick, and Hamilton	2012	A randomized clinical trial of therapeutic community treatment for female inmates: Outcomes at 6 and 12 months after prison release
7	Zlotnick, Najavits, Rohesenow, and Johnson	2002	A cognitive-behavioral treatment for incarcerated women with substance abuse disorder and posttraumatic stress disorder: findings from a pilot study
8	Morash, Kashy, Smith, and Cobbina	2016	The connection of probation/parole officer actions to women offenders' recidivism
9	Blatch, O'Sullivan, Delaney, and Rathbone	2014	Getting SMART, SMART recovery programs and reoffending
10	Singer, Bussey, Song, and Lunghofer	1995	The psychosocial issues of women serving time in jail

Table 2.1

*Summary of Research Articles*

<b>Authors</b>	Wolff et al.	Grills et al.
<b>Year</b>	2012	2015
<b>Study Question?</b>	“Does CBT effective treatment for incarcerated women with mental illness and substance abuse disorder?”	“Does CTC improve women’s well-being pre-release?”
<b>Evaluation Aim</b>	Improve behavioral healthcare for this underserved group	Strong predictor of well-being reduces recidivism
<b>Location</b>	Northeast U.S.	California
<b>Sample Size</b>	74	96
<b>Age</b>	Adults/females	Adults/females
<b>Inclusion Criteria</b>	English speaking offenders with at least 30 weeks left to serve	Voluntarily enrolled
<b>Intervention (IV)</b>	Seeking Safety, a manualized program developed to promote trauma recovery and treat substance use disorder	Choice Theory Connection; Consists of 5 phases for a total of 140 instructional hours.
<b>Treatment</b>	Groups of 6-12 met with a clinician for 90 minutes twice weekly for 14 weeks (42 hour intervention)	4 phases for a total of 140 instructional hours
<b>Design</b>	Open trial design Pre- and post- design	Quantitative
<b>Selection</b>	Women with trauma or met criteria for substance use disorder; Voluntary	All participants voluntarily enrolled
<b>Measures</b>	PCL; Completed an end-of-treatment questionnaire	PSS; PHLMS; DERS; MWA; DHS
<b>Statistical Analysis</b>	Proc means; Freq; T-tests; Corr were used to construct all statistics.	Paired sample; T-tests
<b>Fidelity</b>	Not assessed	Not assessed
<b>Findings</b>	Significant improvements in PTSD, SUD, other mental illnesses	Resulted in improvements in stress, mindfulness, and emotional regulations
<b>Limitations</b>	Methodological limitations causing limited data related to intervention; High drop-out rate	Lack of controlled design; Not enough people qualified to teach intervention
<b>Recommendations</b>	More research with a longitudinal trial design to test effectiveness; SS helped and should be integrated with other interventions	CTC is essential component approach for skills learned in a prison setting

Table 2.2

*Summary of Research Articles, cont.*

<b>Authors Year</b>	Heideman et al. 2016	Lovins et al. 2007
<b>Study Question?</b>	"How do formally incarcerated women define success prior to release?"	"Are HWH and CBCF Effective treatment for female offenders?"
<b>Evaluation Aim</b>	Determine what is needed to achieve success	Determine if interventions work
<b>Location</b>	Southern California	Cincinnati, Ohio
<b>Sample Size</b>	30 formerly incarcerated women	1,340 women
<b>Age</b>	Adults	Adults
<b>Inclusion Criteria</b>	Voluntary; Women were interviewed on their release date	Living at halfway house or in community-based correctional facilities
<b>Intervention (IV)</b>	1 hour and 45-minute qualitative interview where women describe what "success" meant to them.	Completion of program at a Halfway House or a Community based correctional facility.
<b>Treatment</b>	Women were referred to national organizations for formally incarcerated people to help build community support	Specific risk principles per individual
<b>Design</b>	Qualitative and exploratory	Quantitative
<b>Selection</b>	Voluntary	Referrals
<b>Measures</b>	Semi-structured interview	Electronic data base
<b>Statistical Analysis</b>	ATLAS version 6; Thematic analysis	Multivariate logistic regression
<b>Fidelity</b>	Not assessed	Not assessed
<b>Findings</b>	Not reoffending is a portion of "success". Women define success as a process.	Expose intense treatment risk factors for high risk offenders
<b>Limitations</b>	Women who were interviewed were heavily service-connected; Outcomes or definition of success may differ with clients not heavily service connected	Doesn't have good outcomes with low-risk offenders
<b>Recommendations</b>	Increase services after incarceration; Housing status, self-acceptance, recovery, and caretaking on own help women feel supported and help define what is success to them	Interventions work best for women depending on their risk level

Table 2.3

*Summary of Research Articles, cont.*

<b>Authors Year</b>	Ford et al. 2012	Sacks et al. 2012
<b>Study Question?</b>	“Does TARGET or SGT work for incarcerated women struggling with traumatic victimization and/or PTSD?”	“Does a therapeutic community treatment have better outcomes than a CBT group?”
<b>Evaluation Aim</b>	Determine if intervention enhances affect regulation without trauma memory processing	Determine the outcomes of intervention at 6 and 12 months after prison release
<b>Location</b>	Connecticut	Colorado
<b>Sample Size</b>	80 women	468 women
<b>Age</b>	Adult	Adult
<b>Inclusion Criteria</b>	Present issues of PTSD; Participants were screened for eligibility between Jan 2009- Feb 2010	6 months remaining until parole eligibility
<b>Intervention (IV)</b>	TARGET: Twelve 75 minute group therapy sessions with individualized homework; Focuses on psychoeducation. Focusing, recognizing triggers; emotional awareness, evaluating thoughts, defining goals, choosing options and making a positive contribution to the world  SGT: Twelve manualized 75 minute group sessions; Includes experiential self-expression activities and nondirective assistance	Therapeutic community program, 4 hours per day, 5 days a week for 6 months; 15 modules of Cognitive Behavioral Program for substance abuse; 2 hour sessions 3 times a week for 16 weeks
<b>Treatment</b>	TARGET: Twelve 75 minute group therapy sessions with individualized homework.  SGT: 12 manualized 75 minute group sessions	Therapeutic community program; Cognitive behavioral therapy
<b>Design</b>	Quantitative; Preliminary evaluation with 6-month follow up	Quantitative
<b>Selection</b>	Data sample; Voluntary	Voluntary; Then participants were randomly placed in groups
<b>Measures</b>	TESI; CAPS; ASSIST; CORE-OM; TSI; NMR; HOPE SCALE; ETO; WAI-B	BDI-II; PSS-I; BSI; THQ
<b>Statistical Analysis</b>	Chi-squared statistic	Chi-square tests
<b>Fidelity</b>	Research was conducted to ensure fidelity. However, prison regulations prevented taping the sessions in a TARGET or SGT session.	Not assessed
<b>Findings</b>	Findings suggest that relatively brief group therapies teaching affect-regulation skills or facilitating experiential self-expression may benefit incarcerated women with PTSD	The women showed significant improvement at the 6-month and 12-month mark for both groups.
<b>Limitations</b>	To date, largest study evaluating group therapy for PTSD; TARGET is not statistically better than SGT; Needs to be tested with even larger samples	Difference in intensity between groups
<b>Recommendations</b>	A more structured approach to experiential oriented supported group therapy for incarcerated women; TARGET applies skills to process traumatic stress reactions in client's day to day lives.	Therapeutic community treatment in particular is extremely effective for women in reducing drug use, criminal activity and increase mental health

Table 2.4

*Summary of Research Articles, cont.*

<b>Study</b>	Zlotnick et al.	Morash et al.
<b>Year</b>	2002	2016
<b>Study Question?</b>	“Does CBT help incarcerated women with substance use disorder and posttraumatic stress?”	“Can the intensity or support of a PO change the way a client behaves and reduce rearrests?”
<b>Evaluation Aim</b>	Determine if Seeking Safety helps with PTSD and SUD for incarcerated women	Determine if parole/probation officers’ relationship styles play a role in re-arrest
<b>Location</b>		Michigan
<b>Sample Size</b>	Conducted in a “medium security prison”	
<b>Age</b>	18	226
<b>Inclusion Criteria</b>	Adults/females	Adults/females
<b>Intervention (IV)</b>	Women were involved in a residential substance abuse treatment program. All participants met the DSM-IV for PTSD. 12-14 weeks away from release date.	Intensity of supervision on female offenders by their parole officers
<b>Treatment</b>	Seeking safety, consists of 25 topics from a cognitive behavior model	Intensity and behavioral style of Probation officers and Parole officers
<b>Design</b>	90 minutes long in group session twice a week for 12 weeks	Supervision Intensity; Supportive Style; Discuss Relevant issues
<b>Selection</b>	Quantitative; Pretreatment, post treatment and 6 and 12 weeks postrelease.	Quantitative pre/post over 24 months
<b>Measures</b>	Convenience sampling	Convenience sampling
<b>Statistical Analysis</b>	CAPS-I; ASI; HAQ-II; Adherence-Competence Scale	DRI-R; WRNA; DRR; Brief Symptom Inventory Hong T-test; DRI-R Psychological reactance scale
<b>Fidelity</b>	Not addressed	Not addressed
<b>Findings</b>	High degree of acceptance of the treatment. 53% no longer met the criteria of PTSD.	Women who reported responding more negatively to interactions with PO had more arrests and convictions
<b>Limitations</b>	Small Sample size	Dull findings that there is a direct effect on recidivism
<b>Recommendations</b>	More research be done on Seeking Safety. It is a promising approach for treatment of incarcerated women suffering from PTSD and SUD	Women respond more negatively to PO’s who are less supportive and more punitive. Provide training for PO’s the elicits reactance with a more supportive approach that is less anxiety provoking

Table 2.5

*Summary of Research Articles, cont.*

<b>Study</b>	Blatch et al.	Singer et al.
<b>Year</b>	2012	1995
<b>Study Question?</b>	“Is SMART a good intervention to reduce recidivism in men and female offenders?”	“What are our prisons missing as far as Addressing the needs of female inmates?”
<b>Evaluation Aim</b>	Does SMART reduce reconviction outcomes for offenders with significant alcohol or other drug criminogenic needs?	What are the psychosocial issues for women serving time in jail
<b>Location</b>	By addressing substance use disorder while incarcerated we can decrease the percentage of reoffending?	Formulate appropriate rehabilitative interventions
<b>Sample Size</b>	New South Wales	Cleveland House of Corrections
<b>Age</b>	2,882 male and female offenders	201
<b>Inclusion Criteria</b>	Adults male and female offenders	Adults/females
<b>Intervention (IV)</b>	12 session closed group program based on SMART: S-Specific M-Measurable A-Attainable R-Relevant T-Timely	45 to 60-minute interview of inmates. To establish needs of women serving time in jail in hopes to create better services.
<b>Treatment</b>	SMART is a cognitive based recovery program	Offer treatment to inmates based On their needs
<b>Design</b>	12 session closed group. 90 minutes once or twice a week	Interview lasting 45 to 60 Minutes
<b>Selection</b>	Quasi-experimental research design; Quantitative	Close-ended and open-ended questions; Qualitatively analyzed
<b>Measures</b>	Convenience sampling	Randomly selected participants
<b>Statistical Analysis</b>	Propensity score matching; Binary Logistic regression; Analyzed using paired T-tests	Multidimensional Scale of Perceived; Social Support; Brief Symptoms Inventory; Short Drug Abuse Screening Test; Qualitatively analyzed
<b>Fidelity</b>	Not addressed	Not addressed
<b>Findings</b>	Criminal justice agencies cannot rehabilitate with a “one size fits all” type of approach	Present methods of incarceration are neither Effective nor cost efficient.
<b>Limitations</b>	This was an experiment on men and women. There was no way of telling if this intervention worked differently for men	Small sample size Also it’s an old article
<b>Recommendations</b>	Smart participation extended time for reconviction and reduced reconviction rates for general and violent offenders. SMART should be an optional intervention for offender populations.	Development of improvement of services To incarcerated women is an essential step to reducing recidivism



## **Summary of Intervention Studies Used in Systematic Review**

**Demographics.** All 10 clinical interventions were studies conducted between 1995 and 2016. Interventions met the criteria for “clinical interventions for incarcerated women.” Some interventions categorized the characteristics of the women, but not all. For instance, some studies indicated different intervention success rates based on race, marital status, familial support, number of previous arrests, education level, number of children, and socioeconomic status. None of this information was pertinent to this systematic review other than familial support and socioeconomic status except to reinforce the research that suggests the importance of support and access to services after incarceration. The sample sizes ranged from 18 people to 2,882 participants. The number of quantitative participants ranged from 18 to 2,882. The number of qualitative participants ranged from 30 to 201. All but one of the interventions were performed on populations of women. Nine interventions were conducted in the United States, while one was conducted in New South Wales, Australia. For the clinical trials conducted in the United States, three were done on the East Coast, three on the West Coast, one in the Midwest and the other in an undisclosed location. The ages of the women in the studies weren’t specified; some indicated the average age of the incarcerated women was 32. However, all women who participated in the studies were 18 or over.

**Interventions.** I analyzed a wide range of interventions for this systematic review. There were four main themes that were addressed in the clinical interventions: cognitive behavioral therapy, posttraumatic stress disorder, substance abuse disorder, and interventions that reduce recidivism. Five of the trials used a cognitive behavioral framework as their intervention. Two clinical interventions focused on addressing posttraumatic stress disorder. Four interventions were aimed towards treating substance use disorder. Six interventions touched on necessary programs in and outside of prison that could reduce recidivism if implemented. Five of the

studies did post-release follow-ups to help determine the effectiveness of the intervention, mostly at the 3-month, 6-month and/or 12-month mark. Within the context of the intervention, there were either one-on-one interviews, individual sessions, group sessions or a combination of both. Seven of the treatments included one or two weekly sessions for a certain number of weeks. The data from the other three studies was taken from interviews with the women.

**Methods.** Out of the 10 interventions, eight were quantitative; two were qualitative studies. Inclusion criteria ranged from women who were already involved in programming prior to the clinical trial, women who presented with issues of PTSD and SUD, women who had a certain amount of time left before they were up for parole, and women who were already on probation/parole. Nine interventions used convenience sampling, six of which were voluntary. One intervention involved of women who were referred by their parole or probation officer to be part of the study.

Only one intervention out of the 10 mentioned fidelity. The research was conducted to ensure fidelity. However, prison regulations prevented taping sessions. To ensure fidelity there were four therapists who received more than 20 hours of training and case supervision. Nine interventions used measures related to symptoms; the other intervention used a semi-structured interview. The statistical analyses used in the 10 clinical interventions were t-tests, pair-sampling, ATLAS version 6, chi squared statistic tests, thematic analysis, logistic regression and quasi-experimental. Measurements used in the clinical studies were the Psychopathology Checklist (PCL), Philadelphia Mindfulness Scale (PHLMS), Difficulties in Emotional Regulation Scale (DERS), Trauma Events Screening Inventory (TESI), Clinician Administered PTSD Scale (CAPS), Clinician Administered PTSD Scale (CAPS-1), Alcohol Smoking and Substance Involvement Screening Test (ASSIST), Clinical Outcome in Routine Evaluation

(CORE-OM), Treatment Satisfaction Inventory (TSI), Adult Hope Scale (AHS), Workplace Abuse Incivility and Bullying(WAIB), ANNOVA, Addiction Severity Interest (ASI), Health Assessment Questionnaire (HAQII), Dual Role Relationship Inventory (DRI-R), Disaster Risk Reduction (DRR), WRNA, Propensity Score Matching (PSM), and Brief Symptom Inventory (BSI).

**Intervention summary.** All 10 clinical interventions were looking for treatments that would help women with issues for which they were not receiving care prior to incarceration. The interventions addressed certain needs such as substance abuse disorder, posttraumatic stress disorder, mental health issues, psychoeducation, and support, along with access to resources after incarceration. Again, only six of the 10 interventions mentioned that the study was particularly focused on reducing recidivism. However, based on the reason for incarceration and by providing interventions to address those issues, research suggests that these types of interventions would ultimately reduce recidivism.

**Cognitive and behavioral interventions.** Five of the 10 clinical interventions explored the idea of addressing cognitive and behavioral change while females are incarcerated (studies 1, 2, 5, 7, and 9). One of the five clinical studies categorized as addressing cognitive and behavioral interventions (i.e. Wolf et al., 2012) had a primary focus on “Seeking Safety,” a program to promote trauma recovery and treat substance use disorder in inmates with comorbid mental health issues. With the completion level of the intervention at 82%, inmates reported that PTSD symptoms declined. PCL score decreased by 8.5 points which is a reduction of 22% from the average baseline.

The second of the five clinical studies categorized in the cognitive and behavioral interventions (i.e. Grills et al., 2015) had a primary focus on the intervention Choice Theory

Connections (CT or CTC). Grills et al. (2015) stated that “CT emphasizes developing quality emotional relationships with self and others to (a) gain more effective internal control and avoid detrimental external control by others; (b) possess more accurate self-concepts; (c) more effectively manage perceptions, actions and emotions; and (d) create and sustain connections with others to establish meaning and quality relationships. These four dimensions are centerpieces of CT’s capacity to positively affect perceived stress, mindfulness, emotion regulation and impulsivity, and well-being” (p.759). This was a four-phase intervention that consisted of 140 instructional hours. Phase 1 was introductory and Phase 4 was advanced. Phase 4 of CTC reported perceived stress significantly lower than at baseline. According to the PHLMS, CTC improved mindfulness (Grills, 2015). At Phase 4, the intervention reported less emotional deregulation than at baseline. Phase 1 and Phase 4 cohorts reported comparable levels of non-acceptance, goals, impulse, and awareness. CTC showed lasting effects in Phase 4 on improved well-being.

The third of the five clinical studies categorized in cognitive and behavioral interventions (i.e. Ford et al., 2012) had a primary focus on the comparison between Trauma Affect Regulation: Guide for Education and Therapy (TARGET) and Supportive Group Therapy (SGT). TARGET aims to create a skill set to affect deregulation, enhance ability to anticipate and prevent dysregulation, promote equilibrium, and recover from distress associated with traumatic victimization. TARGET is a 12-group (75 minute) group therapy session with individualized homework, compared to a PTSD supportive group therapy which was a 12 manualized (75-minute) group sessions. Both groups showed reduction in PTSD symptom severity. Based on NMR scores, TARGET did not achieve greater improvement in emotional regulation than

support group therapy. However, TARGET participants increased a sense of forgiveness while support group therapy participants reported a decrease.

The fourth of the five clinical studies categorized in cognitive and behavioral interventions (i.e. Zlotnick et al., 2003) had a primary focus on Cognitive Behavioral Therapy and a program called Seeking Safety. Seeking Safety is a program to promote trauma recovery and treat substance use disorders in inmates with comorbid mental health issues. This study particularly focused on the comorbidity with substance use disorder (SUD) and posttraumatic stress disorder (PTSD). The treatment consisted of 90-minute-long group sessions twice a week for 12 weeks. At completion of the Seeking Safety intervention, 53% of participants no longer met the criteria for PTSD; 46% no longer met the criteria for PTSD at the 3-month follow up. However, recidivism rate at the 3-month follow up was at 33%.

The fifth and final of the clinical studies categorized in cognitive and behavioral interventions (i.e. Blatch et al., 2012) had a primary focus on SMART recovery programs. This was the only study that included both men and women; results were not gender specific. The SMART program was made up of 12 sessions that consisted of 90 minutes of motivation and cognitive re-constructing followed by ongoing therapeutic maintenance and behavioral change. The intervention consisted of learning ways to cope with urges, problem solving skills, and psychoeducation on balancing lifestyle. This is also the only study whose primary focus was to enhance the survival time of reconviction and reduce recidivism. It was determined in order for SMART to have a therapeutic effect, inmates must complete 10-11 sessions. There was an average of a 6% reduction in reoffending during the range of the program.

**Support during and after incarceration.** Five of the 10 clinical interventions explored the idea of addressing what women need for support during and after incarceration. Needed

supports included support from family, the community, probation officers, and societal reintegration (studies 3, 4, 6, 8, and 10).

One of the five clinical studies categorized support during or after incarceration (i.e. Heidemann et al., 2016) had a primary focus on how formally incarcerated women define success. Not recidivating was one of five themes that women suggested in an in-depth interview at the time of release. Women defined success as:

1. Success Is Having My Own Place
2. Success Is Helping Family and Others
3. Success Is Living Free from Criminal Justice Involvement
4. Success Is Persevering
5. Success Is The Elusive “Normal Life”

Some literature treats recidivism as the primary indicator of success for this population.

However, according to Heidemann et al., not reoffending is just a small portion of what these formally incarcerated women would describe as “success.” There are many other contributors to a successful life after prison.

The second of the five clinical study categorized in the support during or after incarceration (i.e. Lovins et al., 2007) had a primary focus on risk principle applied to women placed in halfway houses (HWH) or community-based correctional facilities (CBCF). These women were also placed on parole, post release control, or transitional control (Lovins et al., 2007). These researchers used an electronic data base of women who successfully and unsuccessfully completed HWH or CBCF placements, measuring probabilities of failure of completing treatment based on risk level. “There was a 12-percentage point difference between treatment and comparison cases for rearrests, indicating that lower risk women who received

residential treatment were getting arrested at much higher rates than women in the comparison group” (Lovins et al., 2007, p. 391). Rearrests rates for high risk women differed by 14 percentage points.

The third of the five clinical studies categorized in the support during or after incarceration (i.e. Sacks et al., 2012) had a primary focus on therapeutic community treatment and its outcomes at 6 and 12 months after release. Inmates who consented participated in an experimental group called Challenge to Change Therapeutic community program and a cognitive behavioral therapy control group. Challenge to Change met 4 hours a day for 5 days a week over 6 months. The program delivered community therapeutic elements; helped with conflict resolution; and addressed substance abuse, mental health, management, criminal behavior, trauma, and abuse (Sacks et al., 2012). The control group received of a module of 15 cognitive behavioral substance interventions, 2-hour sessions 3 times per week for 16 weeks. Data came from official records and self-report at baseline. The women showed significant improvements within both groups at the 6-month follow-up. Time to reincarceration was longer than 20 days in the experimental group compared to the control group.

The forth of the five clinical studies categorized as support during or after incarceration (i.e. Morash et al., 2016) had a primary focus on the connection between women offenders and probation and parole officers (POs) and its effect on recidivism. This was a longitudinal field study of women on probation and parole. Data was taken from offenders, POs, and official data from state agencies (Morash, 2016). Women who reported responding more negatively to POs had more arrests and convictions after 24 months. Morash stated that, “Considering number of arrests at 24 months as the outcome, the model in which PO supervision intensity was the predictor and recidivism risk was included as a control variable yielded a non-significant

coefficient for supervision intensity. Similarly, when PP supportive behavior was the key predictor of arrests, again controlling for recidivism risk the effect of PO behavior was not significant” (p. 517).

The fifth and final of the five clinical studies categorized as support during or after incarceration (i.e. Singer et al., 1995) had a primary focus on psychological issues of incarcerated women. This qualitative data was analyzed with close-ended and open-ended questions about women’s needs, with social support and sources of help as a main indicator to help them cope. Data suggested that the current methods being used in prison are not effective or cost efficient (Singer et al., 1995). Because the lack of needs being met, Singer et al. was not surprised by the number of women who reoffended.



## **Discussion**

Through a review of 10 clinical interventions, all of which acknowledged clinical and behavioral interventions to inmates as well as support during and after incarceration, I identified differences, similarities, and future questions. These 10 clinical interventions identified the primary focus of reducing recidivism.

Through this systematic review research study, I analyzed what clinical interventions are being used for female offenders as well as added to the body of research concerning high recidivism rates in female offenders. In this research study I examined current literature on interventions and explored certain cognitive and behavioral models to address substance abuse and mental health which was often linked to the criminal behavior. I also focused on identifying the importance of support during and after incarceration on a micro, mezzo, and macro level.

When reviewing the cognitive and behavioral clinical interventions, most of the interventions were successful in validity. However, most of the interventions focused on the reduction of symptoms such as posttraumatic stress, substance abuse disorder, and mental health. Only two of the clinical interventions' primary focus was reducing recidivism. Common findings were that certain clinical interventions did result in a decrease in psychological symptoms, increased emotional regulation, and psychoeducation on life skills.

This research supports the need for a stronger development of interventions that have a primary focus on reducing recidivism. More research is needed on psychological interventions that address the specific needs of incarcerated women incarcerated and interventions after reentry to reduce the chances of reoffending. According to Deschenes, Owen, and Crow (2007), drug and property offenders were most likely to be rearrested for a new crime, but were reincarcerated more quickly than those reincarcerated for a new crime and women who were incarcerated for violent crimes. These results suggest that psychological need and societal need for support are

equally as important to reduce recidivism in female offenders. There is a significant lack of research that explores reducing recidivism. Most of the clinical interventions focused on decrease of psychological symptoms such as substance use disorder, mental health, and post-traumatic stress. Finding these 10 clinical interventions was difficult and only two of them had a primary focus on reducing recidivism as the main goal. None of my clinical interventions were found in social work databases.

### **Strengths and Limitations**

**Strengths.** A strength of this systematic review is that there is significant research supporting the importance of gender specific treatments. According to Flower (2010), “Female offenders are different from male offenders in many ways. Generally speaking, the pathway taken into and along the road of criminal behavior is influenced by life, experience and gendered perspectives” (p. x). Addressing the specific needs that tend to affect women predominately will enhance their chances of being successful after release.

Additionally, it’s a strength that the literature is finally acknowledging that current rehabilitation practices for female inmates is not working, that new methods of administering services are needed. Psychological services essential for incarcerated women, as well as life skills, training, vocational training, and opportunities for education. The literature indicates significant barriers that contribute to women reoffending and making reentry extremely difficult, including barriers of education, social stigma, and lack of employment (Flowers, 2010).

**Limitations.** A significant limitation of this systematic review is the lack of databases; only two were able to provide any type of intervention for this systematic review. From both databases, only 10 clinical interventions could be used for this systematic review. Although all 10 clinical interventions did touch on recidivism, it was not the primary focus of eight of them.

They focused instead on addressing the psychological needs or supportive needs of the women with the intention that, by solely addressing those needs, they could reduce recidivism. There is a need for programs that address both needs with a primary focus on reducing recidivism.

Also, these interventions cannot be representative of the female inmate population. One of the interventions was conducted in Wales and the rest were conducted in different parts of the United States. Some of the studies were far too small to determine if the interventions would actually work on women in prison and it wasn't possible to determine if they just happened to work for this small group of participants. For these reasons, there was an underrepresentation of incarcerated women. Although most of the 10 clinical interventions used for this systematic review had successful outcomes, there were still limitations. Limitations were found in sample sizes, fidelity, and drop outs.

### **Implications for Further Social Work Practice**

I was not able to locate a single clinical intervention about reducing recidivism in the social work database. This brought up the question of whether social workers are working to reach this particular population. From the literature, I am aware that many social workers are being hired as "reentry" coordinators, which is a mandated position by the "Second Chance Act" implemented by President Obama in 2010. These coordinators are hired to help federal offenders reenter society with as many resources as possible.

The reason it is important for social workers to become more involved with the prison population is because social workers can play an important role in helping ex-offenders reintegrate into society. Social workers are taught how to work with clients from a micro, mezzo, and macro stance. Inmates facing re-entry are vulnerable to stigma on all three of these levels.

Further social work practice would benefit from a better understanding of how social workers can help this population from a micro, mezzo, and macro level. Understanding in-depth the barriers this population faces can help social workers advocate for clients' needs. When it comes to welfare, housing, employment, and education, social workers have an understanding of how to access resources.

### **Implications for Clinical Social Work Practice**

Clinical social work is critically important to this population. Because I could not locate one clinical intervention on reducing recidivism in any social work database, I conclude that there has been little research conducted in this area, leaving a huge gap in the literature. Social workers can work with inmates for individual and group therapy. They can administer sessions on cognitive behavioral therapy (CBT) techniques and Dialectical Behavioral Therapy (DBT) techniques.

Some significant recommendations that are missing from the literature are incorporating therapies that include clinical interventions in prison and after prison to specifically reduce recidivism. Researchers could also use larger samples and longitudinal studies to obtain sufficient data on what reduces recidivism in female offenders.

## **Conclusion**

This systematic review focused on how to reduce recidivism among female offenders by selecting and analyzing 10 clinical interventions. Some of the findings were successful in their efforts to find ways to reduce recidivism.

Female offenders are one of the fastest growing populations in the criminal justice system in the United States. There is a large body of literature acknowledging this issue and the idea of gender specific treatment. However, there is gap in interventions that are actually measurable in reducing recidivism. Modern prisons have strayed far from their original intention, which was to encourage rehabilitation; in the 21<sup>st</sup> century, very few programs exist that promote rehabilitation in prison. This creates significant barriers to successful reentry into society. Social workers should educate each other and be aware of the significant barriers this specific population faces, creating motivation to design and implement new interventions that can help reduce recidivism.

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